



1.HealthNet Policy Number	I038-000-117222667-01	2. Authorization Code:
2.Patient Name	YOUNESS JABRAN	
3.Patient Date of Birth & Sex	23-07-86(dd/mm/yy)	☒ Male ☐ Female
5.Nature of illness or Injury	Mobile No.0501698468	
6.Are You the patient's primary physician	☐ Acute ☐ Chronic ☐ Emergency	
7.Presenting Complaints:	☐ Yes ☐ No	
co muscle pain on the neck 29th july 20124 oe chest is clear no added sounds restless		
8.Duration of Symptoms:		
9.Onset of Condition:		
10.Relevent Past Medical/Surfgical History		
DiagonosisiMuscle spasm of back, Pain, unspecified	ICD Code M62.830, R52	
12.Etiology:		
13.In case of Injury:mode of Injury/place of Injury		
14.Plan / Details of Management		
a.ProcedureUric Acid Blood,Rheumatoid Factor Quantitative,Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or familys needs.		CPT code84550,86431,9

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

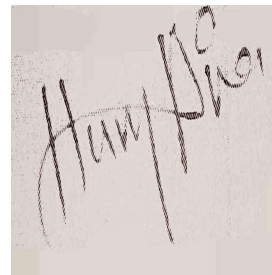
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (100G, TUBE)	1	Take 1Gel 1Time(s) perDay For 1 Day(s) others
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	SUGAR COATED TABLETS (30S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others

Date: 02-08-24(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Physician Code DHA-P-54155530 HNM Code

Authorization

I hereby authorize the Physician, Hospital or Pharmacy to file a claim for medical services on my behalf and I confirm that the above mentioned examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other person who has provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medical condition or medical services and copies of all medical and hospital records.

A Photocopy or teletax copy of this authorization shall be considered effective any valid as the original

Date: 02-08-24(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)

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